

1
M
X
I
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
M
X
I
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
9218
CERTIFICATE OF DEATH
09208

1. PLACE OF DEATH a. COUNTY Kent b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Golt c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY Kent c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Golt d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First Ernest Middle Allen Last Allen				4. DATE OF DEATH Month August Day 1 Year 1961											
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 25 1891		9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor				10b. KIND OF BUSINESS OR INDUSTRY Masonry				11. BIRTHPLACE (County & State, or foreign country) Georgia				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Lum Allen				14. MOTHER'S MAIDEN NAME Nancy Rutter											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO. 221-05-2149		17. INFORMANT Elizabeth Allen		Address Golt Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute coronary occlusion 420.1 DUE TO (b) Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) Degeneration of the heart muscle										INTERVAL BETWEEN ONSET AND DEATH 3-4 yrs 3-4 yrs					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) MILLINGTON		(County) MD.		(State) MD.			
21. I certify that (I) (this hospital) attended the deceased from Sept 6 19 60 to July 31 19 61 that (I) (we) last saw the deceased alive on July 4 19 61 , and that death occurred at 11 P.M. from the causes and on the date stated above.															
22a. SIGNATURE G. E. Z. KORALEWSKI M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. ADDRESS MILLINGTON MD.				22c. PHYSICIAN'S NAME (Type) G-E-ZA KORALEWSKI				22d. DATE SIGNED Aug 2. 61			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF Aug. 4, 1961		23c. NAME OF CEMETERY OR CREMATORY Dales Cemetery				23d. LOCATION (City, town or county) Middletown Del.					
24. FUNERAL DIRECTOR'S SIGNATURE Edward Pillow				ADDRESS Millington Md.				25a. REC'D BY REGISTRAR AUG 7 '61				25b. REGISTRAR'S SIGNATURE Arthur L. Travis			

(M)

(1)

0212

1941

1941

1941

1941

1941

1941

1941

1941

1941

1941

1941

1941

1941

1941

1941

1941

1941

1941

1941

1941

1941

1941

1941

1941

1941

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9219

CERTIFICATE OF DEATH

08209

1. PLACE OF DEATH a. COUNTY Kent MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Md. b. COUNTY Kent			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Golt				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Golt			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 3yrs.				d. STREET ADDRESS Golt			
3. NAME OF DECEASED (Type or print) George S. Beatty				4. DATE OF DEATH Month Aug. 22, Day 1961			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 17, 1870	
9. AGE (In years last birthday) 91 yrs.		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Construction	
11. BIRTHPLACE (County & State, or foreign country) Penna.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME George D. Beatty				14. MOTHER'S MAIDEN NAME No record Yarnall			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) ---				16. SOCIAL SECURITY NO. ---			
17. INFORMANT George D. Beatty Golt Md.				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c) Chronic myocardial						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Smoking						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) W		20c. TIME OF INJURY Month, Day, Year Hour e.m. 19 p.m. 20		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from 9/1 , 19 61 , to 9/22 , 19 61 , (that (I) (we) last saw the deceased alive on 9/15 , 19 61 , and that death occurred at 4 PM , from the causes and on the date stated above.							
22a. SIGNATURE @ H Metcalfe M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 8/23/61	
22c. PHYSICIAN'S NAME (Type) C H METCALFE				22d. ADDRESS Penikese Island, Ind.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Aug. 26, 1961		23c. NAME OF CEMETERY OR CREMATORY Baptist Lower Maerion Cemetery		23d. LOCATION (City, town or county) Bryn Mawr Pa.	
24. FUNERAL DIRECTOR'S SIGNATURE Edward P. Mellington				25a. REC'D BY REGISTRAR DATE AUG 25 '61		25b. REGISTRAR'S SIGNATURE Arthur S. House	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9220

09210

1. PLACE OF DEATH a. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY Kent	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Millington. Rural - HOME		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Millington. Rural	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First John Middle U. Last Chance		4. DATE OF DEATH Month August Day 28 Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March, 17, 1874
9. AGE (In years last birthday) 87 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer Retired.	
11. BIRTHPLACE (County & State, or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Daniel M. Chance		14. MOTHER'S MAIDEN NAME Mary Chance	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO. None.	
17. INFORMANT Dudley Chance, Rural Millington, Md.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis DUE TO (b) Cerebral arteriosclerosis CONDITIONS, if any, which gave rise to immediate cause (e), stating the underlying cause last. (c) Senility	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	
20c. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20e. (City or town)		20f. (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 28 Aug 61 to 28 Aug 61 , that (I) (we) last saw the deceased alive on 28 Aug 61 , and that death occurred at 2p M , from the causes and on the date stated above.		22a. SIGNATURE Wallace Garner Obenshain M.D.	
22b. DATE 29 Aug 61		22c. PHYSICIAN'S NAME (Type) Wallace Garner Obenshain, M.D.	
22d. ADDRESS Cecilton, Maryland		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
23b. DATE THEREOF Aug. 31, 1961		23c. NAME OF CEMETERY OR CREMATORY Church Hill Cemetery	
23d. LOCATION (City, town or county) Church Hill,		23e. (State) Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Edward Fellows		25a. REC'D BY REGISTRAR AUG 31 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. House			

M

1

Ken

Ken

William, Rural

William, Rural

John

John

John

John, 12, 1941

John, 12, 1941

John, 12, 1941

John, 12, 1941

John, 12, 1941

John

John, 12, 1941

John, 12, 1941

John, 12, 1941

John

John

John

John

John

John, 12, 1941

John, 12, 1941

John

John, 12, 1941

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

08211

9221

1. PLACE OF DEATH a. COUNTY Kent MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE B Maryland b. COUNTY Baltimore City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RFD Chestertown				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Chesapeake Bay near Tolchester Beach				d. STREET ADDRESS 6220 Brook Ave 3V01-4			
3. NAME OF DECEASED (Type or print) James Michael Cyran				4. DATE OF DEATH Aug. 13, 1961			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/6/1933	
9. AGE (In years last birthday) 28 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Vending Machine Co. Employee				10b. KIND OF BUSINESS OR INDUSTRY Maryland			
11. BIRTHPLACE (State or foreign country) USA				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Stanley J. Cyran				14. MOTHER'S MAIDEN NAME Annabelle (Last Name Not known)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes				16. SOCIAL SECURITY NO. 212305849		17. INFORMANT Mrs Carol Marie Cyran	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Probably Drowning DUE TO Boating accident in Chesapeake Bay near Tolchester Beach (RFD Chestertown, Md.) Conditions, if any, which gave rise to immediate cause (b) (c) stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH Short			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. boat sank				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Chesapeake Bay		20f. (City or town) (County) (State) Kent Co. Maryland	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Robert W. Farr				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Robert W. Farr				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 8-18-61		22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck 5305 Harford Rd.				24a. REC'D BY REGISTRAR DATE AUG 18 '61		24b. REGISTRAR'S SIGNATURE Arthur J. Harris	

MEDICAL CERTIFICATION

TO DEPT. OF HEALTH: This certificate should be executed within 24 hours after death. If any of the information is necessary, please execute the certificate, with the word "pending" in pencil in Item 18. Give Pages 1, 2, 3, and 4 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE OF MARYLAND
DEPARTMENT OF HEALTH
Baltimore, Maryland

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9222

CERTIFICATE OF DEATH

Items 3 & 16 Film G294 9/13/61 iwc

09212

1. PLACE OF DEATH a. COUNTY <div style="text-align: center; font-size: 1.5em;">Kent</div> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <div style="text-align: center; font-size: 1.5em;">Chestertown</div> c. LENGTH OF STAY IN 1b <div style="text-align: center; font-size: 1.5em;">2 hrs.</div> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <div style="text-align: center; font-size: 1.5em;">Kent & Queen Anne's</div>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <div style="text-align: center; font-size: 1.5em;">Maryland</div> b. COUNTY <div style="text-align: center; font-size: 1.5em;">Kent</div> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <div style="text-align: center; font-size: 1.5em;">Chestertown</div> d. STREET ADDRESS <div style="text-align: center; font-size: 1.5em;">107 High Street</div>			
3. NAME OF DECEASED (Type or print) First Middle Last <div style="text-align: center; font-size: 1.5em;">Dec Dover / Leroy LeRoy Doub</div>		4. DATE OF DEATH Month Day Year <div style="text-align: center; font-size: 1.5em;">8 4 19 61</div>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX <div style="text-align: center; font-size: 1.5em;">Male</div>		6. COLOR OR RACE <div style="text-align: center; font-size: 1.5em;">White</div>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <div style="text-align: center; font-size: 1.5em;">Supervisor Steam plant-Penna. Railroad</div>		10b. KIND OF BUSINESS OR INDUSTRY <div style="text-align: center; font-size: 1.5em;">Railroad</div>		11. BIRTHPLACE (County & State, or foreign country) <div style="text-align: center; font-size: 1.5em;">Maryland</div>			
13. FATHER'S NAME <div style="text-align: center; font-size: 1.5em;">David Doub</div>		14. MOTHER'S MAIDEN NAME <div style="text-align: center; font-size: 1.5em;">Alice Kenny</div>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <div style="text-align: center; font-size: 1.5em;">no</div>		16. SOCIAL SECURITY NO. <div style="text-align: center; font-size: 1.5em;">don't know</div>					
17. INFORMANT Address <div style="text-align: center; font-size: 1.5em;">Dover L. Doub (previous adm.) Chestertown, Md.</div>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <div style="font-size: 2em; margin-left: 20px;">420.1</div> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <div style="font-size: 1.5em; margin-left: 20px;">Myocardial infarction - Arterio sclerosis - Chronic pulmonary congestion</div> </div> <div style="width: 15%;"> INTERVAL BETWEEN ONSET AND DEATH <div style="font-size: 1.5em;">1 day years</div> </div> </div> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <div style="font-size: 1.5em; margin-left: 20px;">Chronic renal insufficiency</div>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <div style="text-align: center; font-size: 1.5em;">19</div>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 			
20f. (City or town) 		(County) 		(State) 			
21. I certify that (I) (this hospital) attended the deceased from <div style="font-size: 1.5em;">8-3</div> 1961, to <div style="font-size: 1.5em;">8-4</div> 1961, that (I) (we) last saw the deceased alive on <div style="font-size: 1.5em;">8-4</div> 1961, and that death occurred at <div style="font-size: 1.5em;">9 P.M.</div> from the causes and on the date stated above.							
22a. SIGNATURE <div style="font-size: 1.5em;">Harry Paul Ross</div>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <div style="font-size: 1.5em;">8-5-61</div>			
22c. PHYSICIAN'S NAME (Type) <div style="font-size: 1.5em;">HARRY PAUL ROSS</div>		22d. ADDRESS <div style="font-size: 1.5em;">203 N. Queen Chestertown, Md</div>					
23a. BURIAL, CREMATION, REBURY (Type) <div style="text-align: center; font-size: 1.5em;">Burial</div>		23b. DATE THEREOF <div style="text-align: center; font-size: 1.5em;">8/8/61</div>		23c. NAME OF CEMETERY OR CREMATORY <div style="text-align: center; font-size: 1.5em;">Chester Cemetery</div>			
23d. LOCATION (City, town or county) <div style="text-align: center; font-size: 1.5em;">Chestertown, Md.</div>		(State) 					
24. FUNERAL DIRECTOR'S SIGNATURE <div style="font-size: 1.5em;">J. Wells Wells</div>		ADDRESS <div style="text-align: center; font-size: 1.5em;">Chestertown, Md.</div>		25a. REC'D BY REGISTRAR DATE <div style="font-size: 1.5em;">AUG 8 '61</div>			
		25b. REGISTRAR'S SIGNATURE <div style="font-size: 1.5em;">Arthur L. Hanna</div>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

222

Hand

Hand

Hand

Handwritten

Handwritten

Handwritten

Handwritten

Handwritten

Handwritten

Handwritten

Handwritten

Handwritten

Handwritten

Handwritten

Handwritten

Handwritten

Handwritten

Handwritten

Handwritten

(1)

Reg. Dist. No. 09213

9223

1. PLACE OF DEATH a. COUNTY KENT		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY —	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETTERTON		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		SV01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Hotel Rigby				d. STREET ADDRESS 805 St. Paul Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) DAVID				First FINCH		Middle —	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 13, 1887	
9. AGE (In years last birthday) 74		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Night Clerk		10b. KIND OF BUSINESS OR INDUSTRY Madison Apts.		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
13. FATHER'S NAME Rowland Finch				14. MOTHER'S MAIDEN NAME Georgella Ramey			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-34-3377		INFORMANT Address A Mrs. Eleanor K. Finch 812 Beaumont Ave. 12			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 433.1 IMMEDIATE CAUSE (a) Centricular Fibrillation DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic auricular fibrillation DUE TO (c) ?							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Acute pyelonephritis							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 14, 1961 , to August 17, 1961 , that I last saw the deceased alive on August 14, 1961 , and that death occurred at 2 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Florence Deringer Joyce MD DATE SIGNED 8-15-61							
ACTUAL SIGNATURE		PHYSICIAN'S NAME (Type) FLORENCE DERINGER JOYCE WORTON, MD					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/17/61		22c. NAME OF CEMETERY OR CREMATORY Greenmount Ave.		22d. LOCATION (City, town, or county) (State) Baltimore Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm J. Tschner & Sons				ADDRESS North & Penn Ave. Balt 17 Md		24a. REC'D BY REGISTRAR DATE AUG 17 '61	
						24b. REGISTRAR'S SIGNATURE Arthur S. Haines	

VS A15 (4)
ISM 9/S8

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9224

CERTIFICATE OF DEATH

09214

1. PLACE OF DEATH a. COUNTY Kent, Chestertown, MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Queen Anne									
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Chestertown				c. LENGTH OF STAY IN lb four days									
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Kent and Queen Anne's Hospital				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Chestertown, R. D.									
d. STREET ADDRESS 17X				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First Middle Last Walter H. Hadaway, Jr.				4. DATE OF DEATH Month Day Year August 5 19 61									
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 17, 1891		9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer				10b. KIND OF BUSINESS OR INDUSTRY Farming				11. BIRTHPLACE (County & State, or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Walter H. Hadaway, Sr.				14. MOTHER'S MAIDEN NAME Virginia Miller				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No				16. SOCIAL SECURITY NO. 220-34-9204	
17. INFORMANT Hospital Records - Chestertown, Md.				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 061X DUE TO Conditions, if any, which gave rise to immediate cause (b) (e), stating the underlying cause last, (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Tetanus INTERVAL BETWEEN ONSET AND DEATH 10 Days				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Hour e.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Chestertown, Md.		20g. (County) Queen Anne		20h. (State) Md.	
21. I certify that (I) (this hospital) attended the deceased from 8/1/1961 to 8/5/1961, that (I) (we) last saw the deceased alive on 8/5/1961, and that death occurred at 8:40 P.M. from the causes and on the date stated above.													
22a. SIGNATURE Thomas J. Solon				M.D. THOMAS SOLON				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS Chestertown, Ind.				22b. DATE SIGNED 8/6/61	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE THEREOF 8/8/61		23c. NAME OF CEMETERY OR CREMATORY Wesley Chapel				23d. LOCATION (City, town or county) (State) Rock Hall Md			
24. FUNERAL DIRECTOR'S SIGNATURE Edgar L. Lane				ADDRESS Church Hill, Md.				25a. REC'D BY REGISTRAR AUG 10 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kline			

5892

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

(M)

(I)

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
9225											
CERTIFICATE OF DEATH											
09215											
1. PLACE OF DEATH a. COUNTY Kent b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown c. LENGTH OF STAY IN 1b 3 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Kent & Queen Anne's Hospital						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Kent c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rock Hall (rural) d. STREET ADDRESS RFD#1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Nettie Middle Frances Last Mercer						4. DATE OF DEATH Month 8 Day 1 Year 19 61					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/1/93		9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas Poole						14. MOTHER'S MAIDEN NAME Barbara Zellers					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 213 14 1221		17. INFORMANT Mrs. Catherine Williams, Rock Hall, Md. (daughter) Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intracranial hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Coronary arteriosclerosis & Congestive heart failure										INTERVAL BETWEEN ONSET AND DEATH 5 days	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Chestertown		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7/27 , 19 61 , to 8/1 , 19 61 that (I) (we) last saw the deceased alive on 8/1/61 , 19 61 , and that death occurred 10 A , from the causes and on the date stated above.											
22a. SIGNATURE Robert W. Farr M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED Aug 1 1961			
22c. PHYSICIAN'S NAME (Type) Robert W. Farr						22d. ADDRESS Chestertown Md.					
23a. (BURIAL) CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Aug 3-61		23c. NAME OF CEMETERY OR CREMATORY Wesley Chapel				23d. LOCATION (City, town or county) (State) Rock Hall Md			
24. FUNERAL DIRECTOR'S SIGNATURE Edgar L. Lane				ADDRESS Church Hill		25a. REC'D BY REGISTRAR DATE AUG 7 1961		25b. REGISTRAR'S SIGNATURE Arthur S. Harris			

1908

Don't get it?

922

Chen, Y. Y.

2005

2. Book: Hall (1994)

Long & Brown Anne's Hospital

1907

2000

5155W

280151

10070

5)

1

.2

2

6315

elaine'

29/1/3

7.

e2search

Analysis

• • •

1005 25000

and 1993 studies.

51

POSTAL CODE

Experimental Laboratory

2755 2

Coronary arteriosclerosis & congestive heart failure

3

5/15/81

52/2

10

58

10

A 01

1990

02879

1991 1 13A

9226

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09216

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Kent		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rock Hall		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown	
c. LENGTH OF STAY IN 1b Short		d. STREET ADDRESS 207 Queen St.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Electric Sub Station (Rock Hall)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) C. Allie Myers		4. DATE OF DEATH Aug. 3, 1961	
5. SEX male	6. COLOR OR RACE white	7. MARRIAGE <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 19, 1902
9. AGE (In years last birthday) 59 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician Maintenance		11. BIRTHPLACE (State or foreign country) Kent CO. Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Edwin Myers	
14. MOTHER'S MAIDEN NAME Mary Emma Brice		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) none	
16. SOCIAL SECURITY NO. 096-09-9220		17. INFORMANT Mrs. Elise Myers Queen St. Chestertown Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ELECTROCUTION</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH <u>NONE</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Accidentally touched 2400 volt line in Electric Substation</u>	
20c. TIME OF INJURY Month, Day, Year <u>11:30 a.m. AUG 3 1961</u>	20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Sub-station</u>	20f. (City or town) (County) (State) <u>ROCK HALL KENT MD</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>O. S. GULBRANDSEN</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Aching</u>	
EXAMINER'S NAME (Type) O. S. GULBRANDSEN M.D.		DATE SIGNED 8/3/61	
22a. BURIAL, CREMATION, or other disposition <u>Burial</u>	22b. DATE THEREOF 8/5/61	22c. NAME OF CEMETERY OR CREMATORY Chester Cemetery	22d. LOCATION (City, town, or county) (State) Chestertown, Md.
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Wells Wells</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 7 '61</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Francis</u>

MEDICAL CERTIFICATION

14

2

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, or 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 4 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9227

CERTIFICATE OF DEATH

Reg. Dist. No. 09217

1. PLACE OF DEATH a. COUNTY KENT MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY KENT	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROCK HALL		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROCK HALL	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First AGNES Middle ROUSE Last ROUSE		4. DATE OF DEATH Month AUG. Day 6 Year 1961	
5. SEX Fem.	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 3 - 1881
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR: Months 80 Days 80 Hours 80 Min. 80	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) IOWA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME RUBEN ROUSE		14. MOTHER'S MAIDEN NAME ROSANNA GOODEN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT MRS. F.R. KENT = ROCK HALL MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardio Vascular DUE TO (c) Arterio Sclerosis			INTERVAL BETWEEN ONSET AND DEATH Unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from July 25, 1961 , to Aug 6, 1961 , that I last saw the deceased alive on Aug 5, 1961 , and that death occurred at 5 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Rock Hall MD. DATE SIGNED MA			
ACTUAL SIGNATURE NORBERT C. NITSCH M.D. ROCK HALL MD.			
PHYSICIAN'S NAME (Type) NORBERT C. NITSCH ROCK HALL MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF AUG. 9	22c. NAME OF CEMETERY OR CREMATORY ST. JOHNS	22d. LOCATION (City, town, or county) (State) ROCK HALL MD.
23. FUNERAL DIRECTOR'S SIGNATURE Edgar L. Lane		24. REC'D BY REGISTRAR Aug 10 '61	
ADDRESS Church Hill Ind.		24b. REGISTRAR'S SIGNATURE Arthur E. K...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

15
9228
M
I
072
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09218

1. PLACE OF DEATH a. COUNTY Kent b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Chestertown c. LENGTH OF STAY IN b. 15 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Kent & Queen Anne's Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Kent c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown (rural) d. STREET ADDRESS RFD#2 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) Thelma Catherine Shinnamon		4. DATE OF DEATH Month 8 Day 14 Year 1961		5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/29/03		9. AGE (In years last birthday) 58 yrs.		IF UNDER 1 YEAR Months 5 Days 15		IF UNDER 24 HRS. Hours 45 Min. 00			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Samuel J. Boyd				14. MOTHER'S MAIDEN NAME Sara H. Scully				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. (If yes give number and date of service)				17. INFORMANT Thelma C. Shinnamon (Hospital records) Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embolism, postoperative DUE TO Conditions, if any, which gave rise to immediate cause (b) 455X (c) 455X DUE TO cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 45 minutes																			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Month, Day, Year Hour a.m. 7-30 p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) 1961 (County) 8-14 (State) 1961							
21. I certify that (I) (this hospital) attended the deceased from 7-30 to 8-14 , 19 61 that (I) (we) last saw the deceased alive on 8-14-61 , 19 61 , and that death occurred at 5:25 a.m. causes and on the date stated above.																			
22a. SIGNATURE A.C. Dick				22b. DATE SIGNED 8-14-61				22c. PHYSICIAN'S NAME (Type) A.C. Dick				22d. ADDRESS Chestertown, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) 8-17-61				23b. DATE THEREOF 8-17-61				23c. NAME OF CEMETERY OR CREMATORY Elkridge				23d. LOCATION (City, town or county) Elkridge Md (State) Md							
24. FUNERAL DIRECTOR'S SIGNATURE McElroy - 130 E. Foulkes				24a. ADDRESS 130 E. Foulkes				25a. REC'D BY REGISTRAR 1661				25b. REGISTRAR'S SIGNATURE Arthur S. Thomas							

2322



Kent

Marjorie

Kent

Chatterbox

13 days

Chatterbox (female)

West & South Kent's Map

REDS

Thomas

Catherine Williamson

LA

X

Female White

2/23/03

58

Hussell

Marjorie

U.S.A.

Samuel J. Boyd

Sam H. Boyd

Thomas C. Williamson (Hospital record)

Temporary embolism, postoperative

8-12-01

7-30

8-12-01

8-1

7:25 a.m.

8-12-01

X

Chatterbox, 20.

A.C. Dick

Only 2 files

SEE LIST

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

Item 9 Film G293 8/21/61 1WK

09219

1. PLACE OF DEATH a. COUNTY Kent b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Chestertown c. LENGTH OF STAY IN 1b 3 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Kent & Queen Anne's Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Kent c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rock Hall d. STREET ADDRESS 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mary Pownall Tierney		4. DATE OF DEATH Month 8 Day 26 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/9/07
9. AGE (In years last birthday) 53/54 Yrs.		10. IF UNDER 1 YEAR Months 5 Days 17 Hours 54 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Vincent Pownall		14. MOTHER'S MAIDEN NAME Bertha Walton	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) no		16. SOCIAL SECURITY NO. don't know	
17. INFORMANT James J. Tierney		Address Rock Hall, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Nutritional and probable electrolyte disturbance DUE TO due to vomiting and refusal to eat Several Weeks (b) Congestive failure 6 months (c) Mitral regurgitation stenosis and insufficiency Many Years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 8/23/61 , 19....., to 9/26/61 , 19....., that (I) (we) last saw the deceased alive on 8/26/61 , 19....., and that death occurred 10:25 AM from the causes and on the date stated above.			
22a. SIGNATURE Robert W. Farr M.D.		22b. DATE SIGNED 8/27/61	
22c. PHYSICIAN'S NAME (Type) Robert W. Farr		22d. ADDRESS Chestertown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 8/28/61	
23c. NAME OF CEMETERY OR CREMATORY Silverbrook Crematory		23d. LOCATION (City, town or county) (State) Wilmington, / Dela.	
24. FUNERAL DIRECTOR'S SIGNATURE Willis Wells Chestertown, Md.		25a. RECORD BY REGISTRAR DATE 8/29/61	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

M

1

Honorable

James A. H. H. H.

James A. H. H. H.

James A. H. H. H.

James A. H. H. H.

James A. H. H. H.

James A. H. H. H.

James A. H. H. H.

James A. H. H. H.

James A. H. H. H.

James A. H. H. H.

James A. H. H. H.

James A. H. H. H.

James A. H. H. H.

James A. H. H. H.

James A. H. H. H.

James A. H. H. H.

James A. H. H. H.

James A. H. H. H.

James A. H. H. H.

James A. H. H. H.

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

3
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9230

CERTIFICATE OF DEATH

Item 2 Film 0293

8/18/61

-ITEM #13 - SEE BIRTH CERTIFICATE

03220

1. PLACE OF DEATH a. COUNTY KENT b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHESTERTOWN c. LENGTH OF STAY in 1b LIFETIME d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) KENT & QUEEN ANNE'S HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE MARYLAND b. COUNTY KENT c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Still Pond d. STREET ADDRESS KENT & QUEEN ANNE'S HOSPITAL a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) HARRY LEWIS First Middle Last 4. DATE OF DEATH AUGUST 13 1961 Month Day Year		5. SEX MALE 6. COLOR OR RACE NEGRO 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH AUG 13, 1961 WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (In years last birthday) 25 yrs. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) KENT - MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S BORN	
13. FATHER'S NAME LEWIS		14. MOTHER'S MAIDEN NAME MARY WALLEY	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT HOSPITAL RECORDS		Address CHESTERTOWN, MD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) FETAL AATALECTASIS 762.5 DUE TO PREMATURITY (22wks 1lb 3oz) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH 2-2 1/2 h.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from AUG 13, 1961 to AUG 13, 1961 , that (I) (we) last saw the deceased alive on AUG 13, 1961 , and that death occurred at 6:15 AM, from the causes and on the date stated above.			
22a. SIGNATURE O. S. GULBRANDSEN		22b. DATE SIGNED 8-13-61	
22c. PHYSICIAN'S NAME (Type) O. S. GULBRANDSEN, M.D.		22d. ADDRESS CHESTERTOWN, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 8-14-61	
23c. NAME OF CEMETERY OR CREMATORY MT. ZION CEMT		23d. LOCATION (City, town or county) (State) STILL POND, MD.	
24. FUNERAL DIRECTOR'S SIGNATURE Victor H. Kennedy		25a. REC'D BY REGISTRAR AUG 15 '61	
ADDRESS STILL POND, MD.		25b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

2072316XV0

0689

(M)

(C)

(I)

1944-1945
1946-1947
1948-1949
1950-1951
1952-1953
1954-1955
1956-1957
1958-1959
1960-1961
1962-1963
1964-1965
1966-1967
1968-1969
1970-1971
1972-1973
1974-1975
1976-1977
1978-1979
1980-1981
1982-1983
1984-1985
1986-1987
1988-1989
1990-1991
1992-1993
1994-1995
1996-1997
1998-1999
2000-2001
2002-2003
2004-2005
2006-2007
2008-2009
2010-2011
2012-2013
2014-2015
2016-2017
2018-2019
2020-2021
2022-2023
2024-2025

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9231

92221

1. PLACE OF DEATH a. COUNTY <u>KENT</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>KENT</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>CHESTERTOWN</u>		c. LENGTH OF STAY IN lb <u>1 1/2 days</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>CHESTERTOWN 37</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>KENT & GREEN ANNE'S GEN.</u>				d. STREET ADDRESS <u>212 COURT ST.</u>			
3. NAME OF DECEASED (Type or print) <u>DONNA LYNN WILSON</u>		4. DATE OF DEATH <u>AUG. 21 1961</u>		5. SEX <u>Fe.</u> 6. COLOR OR RACE <u>N</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>AUG. 19, 1961</u>	
9. AGE (In years last birthday) <u>34</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AM.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>AM.</u>	
13. FATHER'S NAME <u>JESSIE - WILSON JR.</u>				14. MOTHER'S MAIDEN NAME <u>NORMA JEAN BLACK</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>HOSPITAL RECORDS</u>		17. INFORMANT <u>HOSPITAL RECORDS</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Foetal Atelectasis</u> <u>762.5</u> DUE TO <u>PREMATURITY</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour e.m. p.m. <u>19</u>		20d. INJURY OCCURRED While et work <input type="checkbox"/> Not While et work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>8-19-61</u> <u>8:21 PM</u> to <u>8-21-61</u> <u>6:15 AM</u> , that (I) (we) last saw the deceased alive on <u>19</u> and that death occurred at <u>6:15 AM</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Harry Paul Koss</u>				22b. DATE SIGNED <u>1961</u>		22c. PHYSICIAN'S NAME (Type) <u>HARRY PAUL KOSS</u>	
22d. ADDRESS <u>203 N. Queen St</u>		22e. CITY OR TOWN <u>Chestertown, Md.</u>		22f. COUNTY <u>Kent</u>		22g. STATE <u>Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8/22/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>MORNEC CEM.</u>		23d. LOCATION (City, town or county) (State) <u>near Chestertown, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Bennett W. Wadley</u>				25a. REC'D BY REGISTRAR <u>AUG 24 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>	

3072 141 XV0

1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26